CHAPTER 2

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# Human health as a context of the andragogical discourse

## Introduction

The phenomenon of health is an integral part of human life and, moreover, the level of health decides in a significant way about quality of life by setting the limits of physical capacity and biological independence as well as the frameworks of psychosocial functioning. Therefore health with all its deficiencies is somehow integrated into the process of experiencing one's own life, the world, and any relationship with another man. This statement is fully justified by the fact that the concept of health functions not only in medicine and physical culture sciences, but also in the humanities and social sciences. The issue of health is clearly present in pedagogy. The category of health and upbringing for health can be found in the history of education and teaching ideas, and today it enters the main trends in the pedagogical discourse. Its theory is based on the salutogenic perspective of health and approaches that connect human health with quality of life.

## The salutogenic health paradigm as the theoretical background of the pedagogical discourse

The salutogenic perspective refers to the model of salutogenesis developed in the seventies of the twentieth century by Aaron Antonovsky (Antonovsky, 1979). Its

essence is expressed in the anti-nativist thesis about man's possibility of acquiring health through the use of resources and potentials inherent not only in the sphere of their biology, but also in knowledge and competence, psychological traits, physical characteristics and sociocultural environment in which they live.

Becoming a paradigm today, the salutogenic approach complements the pathogenetic paradigm that has been prevalent for years, according to which health issues focus primarily on the search for the causes of a disease. Although grown in the Cartesian-Newtonian philosophy, the pathogenic approach shaped the profile of the twentieth century medical science leading to spectacular achievements in the field of specialized treatments and advanced medical technology, which also resulted in the dehumanization of medicine and objectification of an ill man. The biomedical assumption saying that every disease has a definite cause related to the physical dimension of human vitality resulted also in a conviction that people are helpless against lurking health dangers and they can defend themselves only with their genetically programmed biological potential.

The response to the pathogenetically oriented medicine was a trend developed in the second half of the twentieth century on the basis of social sciences and health promotion movement, centred around the idea of holism and systems thinking. The definition of health presented in the Preamble to the World Health Organization in 1948 defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Referring to this already classic definition, it is now assumed that human health is an integral, systematically organized whole covering the physical, mental, social and spiritual dimension, which remains in mutual relationships with the surrounding biosphere, culture, physical environment and the social context of life. At the same time, Lalonde's health field concept (1974), commonly accepted today, assumes that the level of health is determined mainly by human lifestyle and health behaviours. The term stands for all habitual and intentional health-related behaviours repeated in everyday life by an individual. These behaviours are shaped by sociocultural factors and subjective determinants, such as health awareness, personality traits and psychosocial competence (also referred to as life skills) of an individual. Taking into account the role of behavioural and environmental factors in determining the level of health and the assumptions of the systems concept of health, it can be said that health is a process which results in the achievement of a specific position on the one-dimensional health-disease continuum by an individual. In this context, the health-shaping process requires adequate knowledge about the factors that increase health potential and health risk factors, and the ability to translate this knowledge into everyday life situations and create favourable conditions for people to implement healthy lifestyle.

Under the assumptions of the modern concept of health, its conditions go far beyond the realm of biology and medical intervention, including a variety of factors inherent on the one hand in culture, politics, economics and complex

environments of life and human activities (family, school, work), on the other hand, in subjective qualities of man – in their psyche and spiritual realm (Sęk, 1997). The recognition of the salutogenic perspective justifies the search for optimization of thus defined health determinants through education and community interventions.

## Pedagogy and adulthood health problems

Historically, pedagogical reflection on health appeared mainly when the concept of health education of children and youth was formed. Focusing pedagogical thinking on human health throughout the life cycle, including all phases of development, from the prenatal stage to old age, occurred only in the previous century with the development of social pedagogy.

Contrary to traditional beliefs, proclaiming that the process of human development is finalized in adulthood, the findings of modern science referring to the principle of progressive development indicate that developmental changes take place constantly throughout the entire life cycle. They occur not only during periods of the generally considered "development" – childhood and adolescence, but also in all stages of adult life, including old age. Although, with the passage of years, regressive changes occur both in the biological and psychological spheres of human functioning, they must be accompanied by progressive changes stimulated by adaptive processes triggered by new developmental tasks occurring in successive stages of life (Matczak, 2003). Adaptive processes must also be triggered in response to the challenges provided by the changing sociocultural reality. In this context, adulthood appears to be a phase of life which requires on-going education and upbringing understood as a process of development assistance.

The multiplicity of roles and tasks undertaken by adults generates a number of risk factors for the deterioration or loss of health. In early adulthood, an individual has to deal with many professional and family life tasks. Activity and involvement related to their implementation often make a man more concerned about their family, business and property than health. As a result of this re-evaluation, they often neglect health issues, but they also practice behaviours that on the one hand support the rapid achievement of professional and material stabilization, but on the other hand, they are a risk factor for deterioration or loss of health. Consequently, middle adulthood is associated primarily with somatic health risks related to the emergence of chronic and lifestyle diseases in the etiology of which an important role is played by elements of long-term unhealthy lifestyle.

Its determinants include irrational diet, low physical activity, smoking, alcohol abuse, lack of sleep and rest, etc.

The period of late adulthood is characterized by a progressive and irreversible deterioration in the functioning of the whole body related to biological aging. In this period, adverse biological effects, often leading to disability, result from a number of social health risk factors – retirement, material deterioration, loneliness associated with the loss of loved ones, the monotony of life and social isolation. Sensory functions often deteriorate with increasing symptoms of deteriorating biological condition of the body, which results in limited contacts with the environment, reduced intellectual function, reduced growth of neural processes, reduced adaptability and often affective disorders.

The combination of biological and social factors determining human health in adulthood, particularly in the phase of aging and old age, generates a number of psychological, social and educational problems. The latter are associated with what Helena Radlińska, the creator of social pedagogy in Poland, refers to as "education for health issues." The education should involve transferring knowledge about health, developing habits and skills to strengthen and improve health, developing a positive interest in health and shaping attitudes to enable application of hygiene principles, effective prevention, rescue, treatment, care and rehabilitation. At the same time the author points out that development can be supported and protected against disorders by acquiring skills necessary to undertake tasks assigned to the various phases of life, and enabling community intervention to prevent adverse impacts of the environment and compensate for deficiencies that hinder the functioning of an individual (Radlińska, 1961).

Health education developed on the grounds of social pedagogy deals with social and environmental determinants of health and disease, and the education process aimed at improving health and life skills conducive to a healthy lifestyle and the related quality of life in every period of human life (Syrek, 2009). The cognitive area of health education includes health education of children and youth along with the course and determinants of their health socialization, as well as the process of universal health education and health socialization for adults (Gaweł, 2007). Above all, it needs to be emphasized, however, that although the category of health is the focal point of research exploration of health education, the issues related to the social reality and pedagogical aspects of somatic and psychosocial functioning of man in illness, disability or old age appear in almost every pedagogical subdiscipline.

Currently, there are two complementary trends in the pedagogical health discourse referred to in the literature as "health pedagogy" and "pedagogy for health" (Szewczyk, 2006). The reflection of "health pedagogy" concerns issues related to the practice of health upbringing and health education at the background of knowledge of social values and norms, social life processes affecting social inequalities in health, psychological contexts of aging and old age, and the mechanisms of human behaviour in health, disease and disability. "Pedagogy

for health" has the practical dimension, and directions of pedagogical activities developed in this stream of research explorations are assumed to serve all those whose social and/or professional roles involve teaching and education activities in the field of health – parents, teachers, educators, health professionals, social workers, organizers of sport, tourism, recreation and leisure time as well as animators of health self-help groups or support groups.

## Health and quality of life

A. Campbell is considered a precursor of research on quality of life. He described it as a life experience expressed with a level of life satisfaction and a sense of happiness (Campbell, 1976). This broad approach allows for the identification of a sense of good-quality life with health understood in terms of a sense of physical, mental, social and spiritual well-being.

The increased interest in the quality of life category observed since the seventies of the 20th century is seen to be rooted in the sociocultural changes associated with the expansion of technological progress in almost all areas of life. Economic development combined with modern technology has resulted in definitely increased welfare in developed countries, generating the growth of consumerism and the dehumanization of society while not noticing the mental and spiritual sphere of life as determinants of the "good life." In the medical science, this phenomenon was manifested by the desire to save and prolong human life with increasingly more sophisticated and extremely invasive therapeutic procedures, in the absence of due care of a patient's quality of life. Progress in medicine in developed societies has also resulted in a diametrically transformed image of diseases in the adult population, especially of the chronic diseases along with frequently associated disabilities resulting from the constant increase in biological age. The shift in the emphasis from "survival" to "quality of life" turned out to be among the manifestations of the widespread criticism of the phenomenon (Jaracz, 2001).

Modern comprehension of quality of life in the social sciences involves objective and subjective approaches. The objective approach treats quality of life as a set of conditions of the physical, physical and sociocultural environment that constitute a context for various spheres of human life and activities – family, education, work, leisure, health, civic life, etc. It is assumed that the conditions, together with somatic and psychological determinants, are reflected in the subjective quality of life, treated as a cognitive and emotional category which involves the assessment and evaluation of different walks of life and life as a whole (Heszen, Sęk, 2007).

The subjective quality of life is sometimes identified with subjective life satisfaction, understood as the resultant subjective assessment of the objective conditions of life and personal values such as good physical condition (e.g. health, mobility, agility), material resources, social contacts and social support, positive emotions, stress resistance, and self-esteem of one's own development and activity.

The quality of life category is also widely recognized in the modern medical science, as a result of which the "new" philosophy of health, whose assumptions refer to the biopsychosocial model of health, is disseminated in the awareness of medical scientists. The humanization of the medical approach to quality of life results in the concept of "health-related quality of life" which defines it in terms of perception of one's own position in life in the context of culture and the system of values in which the person lives, and in relation to their objectives, expectations, standards and concerns (WHO, 1991). An assessment of thus defined quality of life covers the physical, mental and spiritual sphere and social functioning as well as the environmental context of life. Therefore, such an assessment involves a wide range of individual experiences, phenomena, and conditions associated with everyday life. Not only the conditions of life (financial resources, housing conditions, health and social care, the possibility of recreation, physical environment, transport) and feelings associated with the level of somatic functioning (pain and discomfort, fatigue, sleep quality, physical independence), but also the mental and emotional processes, body image and self-esteem, spiritual experience, ability to communicate, ability to work, the level of daily activity and quality of social relationships are taken into account (WHOQOL, 1997). Moreover, concepts derived from the traditions of quality of life studies in philosophy and social sciences that are transferred to medical science complement the humanistic perception of quality of life in medicine.

According to the existential approaches, quality of life is tied to the implementation of one of the two life orientations – "desire to live" or "desire to have." Such a conceptualization of the term discussed involves an approach which identifies quality of life with personal knowledge and emotional reception of the world. Quality of life is thus determined by the quality of individual, everyday experiences, originating in a subjective cognitive system (Trzebiatowski, 2011). This direction in the quality of life analysis seems to have clear pedagogical references. A sense of quality of life in this context is an individual system of values formed in the process of upbringing and education. We should also mention an approach according to which the main components of quality of life include implementation of developmental tasks and life tasks. The former are related to compliance with social expectations attached to social roles, while the latter are implemented in the existential aspects of life. The quality of life experience is expressed in this context with a sense of happiness/unhappiness, the meaning of life/or meaninglessness of life, life satisfaction/ dissatisfaction (Bańka, 1995).

In view of the above findings, it can be said that quality of life is one of the most important concepts merging the pedagogical and medical perspective

of the analysis of human functioning in the modern world. The changing demographic profile of the population and the resultant new health, social and existential problems have made quality of life such an aspect of an individual experience of the world for the assessment of which it is necessary to take into account positive health indicators perceived in terms of physical, psychosocial and spiritual well-being.

## Quality of life development as a matter of prevention, health promotion and pedagogical activities

The linking of health issues and quality of life opens the on-going discourse on the development of subjective and environmental health conditions. The course of the analysis is part of the cognitive area common for social pedagogy, prevention and health promotion.

The concept of prevention is related to activities addressed to an individual and/or a specific population and aimed at preventing the occurrence and development of adverse conditions and events. In terms of the method of determining prevention purposes and ways of their implementation, it can be recognized in two ways: humanistic and medical. The essence of the humanistic perspective is focus on improving quality of life in a broad sense, in particular the ability to use one's potential and to function in the biopsychosocial dimension (Habrat, 2002). Z. Gaś (2002, p. 10) defines prevention as "the process of assisting man in coping with difficulties threatening their orderly development and healthy life, as well as reducing and eliminating factors that interfere with normal development and disorganize healthy life." Therefore, broadly understood preventive measures involve equipping man with qualities and skills conducive to satisfactory life and dealing with potential hazards, and community interventions aimed at minimizing these risks. Thus understood prevention refers to the assumptions of the health promotion movement developing in the seventies of the previous century.

The development of the health promotion concept has its origin in the universal acceptance of the holistic approach to health and the recognition of the role of lifestyle in its conditioning as well as the recognition of a relationship between positive health and quality of life. This concept treats health as man's changeable ability to both reach the top of their physical, mental and social opportunities and to react in a positive way to environmental challenges. In this sense, health is not treated as an autotelic value, but as a means that enables man to use both their inherent abilities and opportunities offered by the surrounding environment to make life better, fuller and richer (Słońska, Misiuna, 1993).

The definition of health promotion adopted at the First International Conference on Health Promotion in Canada (WHO, 1986) states that it is a process of enabling people to increase control over, improve and maintain their health as long as possible at the highest level and to take self-control and self-care in health and disease throughout the life cycle, by making choices and decisions conducive to health. At the same time, it is emphasized that a crucial prerequisite for people to take control over their health is the ability to determine their health needs and access to conditions that will satisfy them. Therefore, health promotion measures on the one hand aim to equip individuals and groups with knowledge and skills, and on the other hand to create conditions that will enable them not only to respond appropriately to health risk, but also to implement healthy lifestyle standards on a daily basis. The former course of action is associated with health education, and the latter requires a cross-sectoral cooperation in the field of environmental measures to ensure adequate political, social and economic conditions which will encourage people to comply with health standards in their daily lives. Health promotion tasks associated with the levelling of social inequalities in access to health care are considered particularly important.

In the documents of the European Union's social policy, health inequalities are primarily associated with social exclusion of people who are for various reasons (not only material) at the bottom of the social ladder (e.g. ethnic minorities or illegal immigrants). Relationships between exclusion and health are described there in three connection systems. Firstly, exclusion is identified with a permanent or temporary lack of access to medical services. Secondly, among the causes of ill-health are social factors comorbid to exclusion, such as poverty, unemployment, lack of education and pathology of family life. Thirdly, poor health is considered a driving force of exclusion due to the fact that it limits access to many spheres of social activity (education, work, etc.) and makes it difficult to create social ties providing social support (Włodarczyk, 2007).

Not only material environment factors and limited access to health protection goods but also differences in lifestyle, habits and healthy and unhealthy behaviours accompanying social stratification are indicated among the social determinants of health inequalities. This long-emphasized phenomenon is confirmed, for example, by the results of studies conducted in 2003/2004 on mutual determinants of health, disease, and poverty among residents of Warsaw (Ostrowska, 2009). These studies have shown that people living in poverty present worse profiles of healthy behaviours as compared to the entire population: they eat less, are less hygienic, spend less time on physical activity, preferring to stay passive, and they are much less likely to undergo preventive examinations. At the same time such people more often practice unhealthy behaviours associated with the use of "legal" psychoactive substances – smoking and alcohol abuse.

The analysis of social inequalities in health in the context of the availability of health resources reveals the pedagogical perspective of the issue discussed.

## The issues of health resources as the background of andragogical reflection

The reference to the biopsychosocial model of health and the definition which treats resources as "objects, conditions, personal characteristics, and energies which are either themselves valued for survival, directly or indirectly, or that serve as a means of achieving these ends" (Hobfoll, 2006, p. 45) suggest that the functions of health resources or deficits may be served by both the characteristics of the subjective and interpersonal world of an individual and the qualities of the environment in which they live. Thus understood health resources are an important point of reference and a theoretical background for the andragogical discourse.

Biological, psychological, and interpersonal properties are considered internal health resources of an individual. Among the psychological resources are temperament and the self-structure – self-acceptance and optimal self-esteem, a sense of identity, a sense of agency and influence on events as well as various forms of control of events and self-control, self-efficacy, a sense of coherence and life skills. The latter are regarded as effective problem-solving skills and the impact on the environment, and can include cognitive skills that affect adaptability in health and disease, emotional competence and social skills, including interpersonal skills in particular (Heszen, Sęk, 2007). The external resources are physical (including biological) environment resources and social and cultural resources. Reference is made in this regard firstly to the health aspects of human material culture – architecture, communication, life environment, education or work. Secondly, the status of a health resource (or deficit) is granted to primary social reference groups (marriage, family, peers, colleagues, friends), associations, self-help groups, professional support groups and various governmental and non-governmental institutions providing and organizing care and education. The group of cultural health resources include elements of cultural phenomena that affect the quality of social resources – customs, traditions, rules of coexistence, regulations, standards as well as systems of cultural references and personal and social development, present in artistic and cultural expression (Sęk, 2003).

Health resources can also be recognized in the context of social capital conditioning health awareness of individuals and their quality of life. In a narrow sense, it refers to resources of information, values, and support that can be gained by an individual through relationships with other people. In a broad sense, social capital for health is identified with the nature and extent of the involvement of people in informal social networks and formal organizations that solve social problems (Theiss, 2004). The multidimensional approach defines social capital as individuals, communities and society. It therefore includes social

resources, collective resources of a neighbourhood or community, economic and cultural resources. Social resources are here identified with informal mutual support of the closest social reference groups (neighbours, colleagues, friends, etc.), while collective resources of a neighbourhood or community are believed to be on the one hand in local associations and voluntary groups or self-help groups, on the other hand in involvement and participation of people, a level of public confidence in local authorities and a sense of belonging and social cohesion (Woynarowska, 2007). This approach to social capital has clear links with a local community which is the main conceptual category of social pedagogy.

However, although unequal access to health care can occur at any stage of human life, it is particularly vivid with the progression of the aging process, in chronic disease and disability.

Documents of the World Health Organization (WHO, 2011) propose to change the perception of aging, even describing it as a new paradigm of aging. It is assumed that old age – as opposed to the traditional approach which treats it as a burden to society – should be considered in terms of potential and social resource. The need to use the same measure in the perception of the young and the old as consumers of social goods and participants in the labour market and social life is emphasized, while recognizing that old people unquestionably contribute to build the prosperity of the communities in which they live. This approach to old age corresponds to the concept of healthy and active aging recommended by the WHO (WHO, 2002). It assumes that the physiological process of aging involving progressive morphological and biochemical changes in cells, tissues, and body composition, a decrease in organ reserves and adaptability to various physical, biological, and psychosocial burdens, requires optimized conditions for health, participation and security of both individuals and groups.

Nationwide health promotion programmes implemented in the European Union are a response to the thus specified tasks promoting health in adulthood. The main objective of the on-going Polish National Health Program (2007) is to improve health and the related quality of life of the population and reduce inequalities in health. Its operational objectives are, among others, to create conditions for a healthy and active life of older people and to create conditions for active life of the disabled. It is expected that the measures taken will on the one hand reduce the prevalence of risk factors for non-communicable diseases in the elderly population, the prevalence of disability, chronic diseases and premature death of people over 60 years of age, and on the other hand they will increase a sense of health, security and active participation in economic, cultural, social and political life of seniors and people with disabilities.

The development of internal and external resources for health is central to measures taken as part of health promotion. Community and social work methods should be developed within the framework of social pedagogy as particularly valuable in carrying out thus specified tasks. The community organisation method

is undoubtedly worthy of attention here, as it aims to support the development of both people and conditions in which they live, as well as care and compensation. The success of this method can be guaranteed by the awakening of social forces as volunteer organizers of collective life. It should be noted that, in a broad sense, the community method emphasizes the dominance of a positive sense of social activities over the negative aspects relating to rescue and removal of threats (Pilch, 2003). This approach to the community method corresponds to the basic tasks and values of health promotion, such as creating health support communities, strengthening local community action for the health of its members, consolidating and expanding partnerships for health and promoting social responsibility for health.

Health promotion tasks and directions of pedagogical measures focused on health and quality of life in adulthood, aging and old age are mutually complementing. In early and middle adulthood, it is particularly important to support humans in carrying out healthy lifestyle activities, while in late adulthood – to take measures to combat social handicap expressed in a less privileged situation of old people resulting from their chronic illnesses or functional disabilities. These activities aim to develop resources for the physical, psychosocial and spiritual well-being of man, and therefore, on the one hand they involve upbringing, education, care and broadly understood support, and on the other hand they are associated with making interventions in their life environment. Andragogy makes a significant contribution to the theoretical basis for strategies to obtain better health and quality of life of adults, because its discourse on human functioning in the life environment is based on the holistic approach to health.

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